

supraclavicular area). Conservative surgery was considered only when the following criteria were met: limited disease size after PSC, no edema, erythema or extensive direct skin infiltration, expected good cosmesis, patient request. Full axillary dissection was performed in all patients.

Results: Main pretreatment characteristics, response to PSC and absence of invasive breast cancer in the breast (pCR) are reported in the table according to the surgical procedure (radical mastectomy or RM vs BCS).

	Total	RM	BCS
No. of patients	471	408	63 (13%)
% cli	12	13	5
% T4d	24	28	6
% T size >5 cm	57	63	22
% ORR	79	78	82
% pCR	3	3	1.5
% pN0	26	24	36

After a median follow-up of 58 months (1–205) local-regional recurrences were documented in a similar percentage of patients, regardless of the type of surgery adopted (local recurrence: RM 5% vs BCS 6%; regional \pm local recurrence: RM 5% vs BCS 5%), while distant metastases were the first site of disease relapse in 36% of patients after RM and in 22% after BCS.

Conclusions: The analysis suggests that in selected patients with LABC treated with PSC, breast conserving surgery plus radiotherapy is feasible, safe and is not exposing patients to a sub-optimal local-regional control. Administered drug therapy, selection criteria and factors predicting the feasibility of BCS will be presented in detail.

520

Poster

Should we follow western guidelines for axillary clearance in breast cancer in developing countries?

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Introduction: The standard guidelines recommend level I and II clearance for operable breast cancer. A majority of patients (more than 65%) treated in the west are node negative. In developing countries, we see larger tumours in operable breast cancers, with a possibility of leaving behind disease in level III, if these recommended guidelines are adhered to.

Methods: We retrospectively evaluated 1175 operable breast cancer patients in the period 2003–2005. The level III axillary nodes were dissected separately during axillary clearance. All operable breast cancer patients who underwent breast conservation surgery and mastectomy, including those who received neoadjuvant chemotherapy, were included in the study. We correlated level III nodal metastasis with the tumor quadrant, tumor size, metastasis in level I and II nodes in the axilla, tumor type, tumor grade and presence of lymphovascular emboli.

Results: The median tumour size was 3 cm and the median number of nodes positive for metastasis was three. Overall, 9.4% of the patients with operable breast cancer had metastasis in the level III axillary lymph nodes. There was a proportional correlation of level III node positivity to number of positive LN in level I and II – node negative had 0.2% skip metastasis in level III; 1–3 positive nodes in level I & II had 4.3% level III node positive rate; 4–9 positive nodes had 32% level III metastasis, and >9 nodes positive had 61% level III nodal metastasis. Incidence of metastasis was similar in tumors from inner and outer quadrants. Level III node metastasis was significantly higher in patients with larger tumours.

Conclusions: We believe leaving behind disease in the axillary apex in nearly 1 in 3 patients is unlikely to satisfy the curative intent of surgery in early breast cancer.

521

Poster

Merits and demerits of parasternal lymph nodes dissection

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Introduction: Based on the results of a randomized controlled study, Milan trial conducted by Veronesi et al., the role of parasternal node (PS) dissection has been considered questionable. However, PS metastasis and recurrence are occasionally encountered and are believed to have a poor prognosis. In our department, PS dissection was actively performed until

2000 in patients with breast cancer measuring ≥ 3 cm and located medially (or bilateral disease). We report the merits and demerits of PS dissection.

Subjects and Methods: The subjects were 171 patients with breast cancer who underwent PS dissection before December 2000. Patients who had PS metastases were reviewed, and the outcome was compared with that in patients without metastases.

Results: Of the 171 patients, 33 (19.3%) were PS-positive. They were aged from 39 to 80 years (mean: 56.7 years) and consisted of 31 patients with Invasive ductal carcinoma, 1 with Mucinous carcinoma, and one with Medullary carcinoma histologically. Seven patients had PS metastases alone (no axillary node involvement). Of the 171 patients undergoing PS dissection, 96 had nodal metastases, comprising 28 PS-positive patients (group A) and 68 PS-negative patients (group B). In group A, 13 patients suffered from recurrence and 15 patients did not. In group B, 16 patients had recurrence and 52 did not. Thus, recurrence was significantly more common in patients who had PS involvement than in those without it.

Conclusion: Although the effect of PS dissection was unclear, the presence or absence of PS metastasis seems to be an important prognostic factor.

522

Poster

Have young women undergone excessive radical surgery without improving survival?

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Introduction: Two percent of all breast cancer appear in young women. In women 35 and under, the diagnostic role of mammograms is debatable. It is also unclear of the necessity of performing mastectomy and that if the overall prognosis worsens. Hormone therapy and ovarian ablation must be considered important therapeutic tools.

The goal of this study was to evaluate the result and survival of the therapeutic strategy in these patients diagnosed and treated for breast cancer in our hospital with a 5 year minimum follow-up and to identify which treatment is the most suitable.

Methods: A retrospective study was carried out on 71 women 35 years old and younger diagnosed with breast cancer in our hospital between 1983–2000. Statistic analysis was carried out with SPSS 13. A survival study was designed with Kaplan–Meier method.

Results: Conservative surgery was performed on approximately half of the patients.

Mastectomized patients presented a significantly higher number of locoregional relapses than conservative surgery ($p = 0.031$). Global survival was similar in patients who underwent conservative and radical surgery. Adjuvant treatment with chemotherapy ($p = 0.61$) did not influence the number of locoregional relapses, but it did influence in distant metastasis. In the group who underwent chemotherapy, a smaller proportion of disease free patients were seen in a 5 year follow-up (44.7% vs 78.3%) ($p = 0.077$). Global survival was similar in both groups.

After having performed a multivariate analysis (ANOVA) considering the tumour size as a confounding factor, it is observed that neither the type of surgery or undergoing chemotherapy influence the prognosis.

Radiotherapy did not influence the global survival rate nor did it influence disease free survival. Patients who were prescribed adjuvant hormone therapy presented a significantly higher number of relapses ($p = 0.011$).

Conclusions: In univariate analysis, patients who underwent mastectomy and those who received chemotherapy experienced the highest number of locoregional relapses and distant metastasis.

With ANOVA the tumour size was the confounding factor and it was shown that neither the type of surgery or chemotherapy influenced in the prognosis.

The 5 year survival of patients who underwent hormone therapy was less favourable. More than 50% patients lived more than 15 years after treatment.

523

Poster

Subcutaneous mastectomy including conservation of the nipple areolar complex: broadening the indications

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Background: Numerous authors consider multiple predictive factors to decide whether the nipple areola complex (NAC) can be preserved or not during mastectomy. These are: tumor-nipple distance, tumor size, axillary lymph-node status and lymphovascular invasion. Thus, only a very limited